SOUTH DAKOTA BOARD OF NURSING

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IN THE MATTER OF THE LICENSURE PROCEEDINGS	:	
	:	**BOARD OF NURSING'S FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER OF REVOCATION**
RE: JAY A. ERICKSON, R.N.	:	
License No. R033909,	:	
Licensee.		

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This matter came on before the South Dakota Board of Nursing ("Board") for a due process hearing on the Summary Suspension of the license of the Licensee, Jay A. Erickson, RN, license number R033909 ("Licensee"), on April 21, 2010, at approximately 3:00 p.m., in the conference rooms of the South Dakota Board of Nursing's office in Sioux Falls, South Dakota. Licensee, Jay A. Erickson, upon receiving Notice of Hearing, appeared personally. The Board appeared by and through its attorney, Kristine Kreiter O'Connell. A quorum of the Board was present in person throughout these proceeding in accordance with SDCL § 36-9-18. Board President Deb Soholt presided over the proceeding.

This was an open meeting under the laws of the State of South Dakota. Six witnesses testified in person. These included the Licensee Jay Erickson, Mary Lou Feterl, Jeanne Galbraith, Joe Broin, Mike Kiewel, and Tim Ripley. The Board considered the Exhibits (numbered 1-7) entered into evidence by the Board and Exhibits (lettered A-

D) entered into evidence by the Licensee. The entire hearing was audio recorded (the testimony of Mike Kiewel did not record) and was later transcribed.

At the close of testimony, the Board moved into executive session, pursuant to SDCL § 1-25-2, to deliberate regarding its decision.

At the close of deliberation, the Board came back into open session with the parties present where one motion was made by the Board, "That the South Dakota Board of Nursing revokes the license of Jay A. Erickson, RN". This motion was adopted on a vote of 9 to 0.

The Board considered the evidentiary testimony of the witnesses, the Exhibits admitted into evidence, and other documents on file in this case, and being charged with the statutory obligation to protect the public health, safety, and welfare as set forth in SDCL § 36-9, including the protection of the public from unsafe nursing practices and practitioners, the Board hereby makes the following:

FINDINGS OF FACT

BACKGROUND

1. That Jay A. Erickson is licensed to practice as a registered nurse in the State of South Dakota and holds license number R033909.

2. Licensee received his nursing degree from the University of South Dakota in 2004.

3. After graduation and licensure, Licensee went to work for Rapid City Regional Hospital for two to two and a half years after graduation until he sustained an

injury in a three wheeler accident.

4. Following recovery from his accident, Licensee took an administrative nursing position as Director of Clinical Education on or about January, 2007 with Golden Living Center in Rapid City. He was reassigned to the patient care floor in November, 2007 after a disagreement with the Executive Director.

5. Licensee left employment at the Golden Living Center on or about May 30, 2008.

6. Following Licensee's employment at the Golden Living Center, Licensee returned to Rapid City Regional Hospital and was assigned to work in the Emergency Room ("ER").

7. Golden Living Center made a complaint against the Licensee to the South Dakota Board of Nursing on June 18, 2008 alleging poor documentation, medication errors, and other nursing practice issues. Investigation was commenced.

8. On or about September 15, 2008, the South Dakota Board of Nursing issued a Letter of Reprimand with Remediation to Licensee.

9. The Licensee petitioned the Board pursuant to ARSD 20:48:11:01 for a hearing on said discipline and appeared before the Board on November 13, 2008 and presented evidence on his own behalf.

10. On November 13, 2008, the South Dakota Board of Nursing moved to rescind the Letter of Reprimand and replace it with a Letter of Concern with the same remediation requirements in regard to documentation and medication errors.

11. Licensee worked twelve hour shifts in the ER, with the majority of these being the night shift from 6:00 p.m. through 6:00 a.m. the following morning.

12. Mary Lou Feterl ("Feterl") is the Director of Nursing at the Rapid City Regional Hospital Emergency Room and has held that position for the last three and a half years. Feterl would have been the Licensee's Director of Nursing since his employment at Rapid City Regional Hospital.

13. Tim Ripley ("Ripley") was one of the charge nurses (CRN) in the ER. He has twenty years of experience and has been the charge nurse in charge of Licensee on many occasions.

14. Ripley, as charge nurse in the Rapid City Regional Hospital Emergency Room, assists with oversight, overflow, staffing, troubleshooting, assisting with procedures, and assigning staff breaks.

15. While working in the ER, Licensee would disappear from the unit, take breaks, and his co-workers did not know where he was. He did not always let others on the unit know where he was.

16. Ripley states that Licensee would disappear two to three times per shift for twenty to thirty minutes each time. These absences occurred occasionally.

17. Licensee felt he was overlooked for breaks, so took them when he could, and approached the Director of Nursing about not getting his breaks.

18. The issue of Licensee's absences from the Emergency Room was discussed with the Licensee. The Licensee was also called into meetings with Feterl, the charge

nurse, and Tim Ripley to discuss this issue. The meetings occurred several times during the last six months of his employment at Rapid City Regional Hospital.

19. The issue of these absences culminated in the months prior to the incidents at issue and Licensee was instructed to communicate better.

20. Licensee made Feterl uncomfortable in regard to his demeanor when he did not get his way or was upset and she felt threatened. It was not necessarily verbal, but it was in his body language.

21. Licensee told a nursing co-worker that she had a "beautiful forehead".

22. Professional staff that worked in the ER were uncomfortable with Licensee's remarks.

23. Ripley had received a complaint from a female nurse who alleged that Licensee backed up to her buttocks and moved back and forth. Ripley encouraged this female nurse to report this incident and is not sure whether she did.

24. Professional female staff in the Emergency Room described Licensee as a "creep".

25. Jeanne Galbraith ("Galbraith") is the Vice President of Quality, Safety, and Risk Management at Rapid City Regional Hospital. She is certified as a Professional Health Care Risk Management and Specialist in Hospital Accreditation.

26. Galbraith is involved with patient issues and regulatory matters, but not employee issues.

27. Joe Broin ("Broin") is a Patient Care Technician (PCT) in the Rapid City

Regional Hospital ER and was working the night shift on Friday, January 22, 2010.

28. Mike Kiewel ("Kiewel") is a security guard at the Rapid City Regional Hospital. Kiewel was working in the ER on the evening of January 22, 2010.

PATIENT NUMBER 12

29. During the night shift on Friday, January 22, 2010, the ER was busy with multiple ambulances arriving, one of which brought in patient number 12. Seven to nine RNs were on staff that night along with four Patient Care Technicians.

30. Patient number 12 had attempted suicide by taking an overdose of medication and, due to her mental state, was vulnerable.

31. On January 22, 2009, the Licensee cared for patient number 12 who had come in via ambulance following an overdose attempt.

32. Patient number 12 came into the ER at 7:00 p.m. and left at approximately 11:00 p.m. She was there for a long period of time due to the need to get a final blood test before she was transferred to a mental health unit outside of the hospital facility.

33. The emergency room at Rapid City Regional was busy the night of Friday, January 22, 2010 when Licensee was caring for patient number 12.

34. The ER on the evening of January 22, 2010 was busier than usual. Thirty-two patients were seen in the ER between 7:00 p.m. and 11:00 p.m., eight of them being admitted to the hospital.

35. Licensee assessed the ER as being slow the night that he cared for patient number 12; so consequently, he had additional time to spend with patient number 12. He

admittedly gave her more time and attention than he would have given any other patient.

36. That on January 22, 2010 Licensee established a nurse/patient relationship with patient number 12, who was brought into the Rapid City Regional Hospital ER.

37. Licensee discussed with patient number 12 her affairs with a number of Rapid City surgeons, her husband's alcoholism, their fighting, and her two children. Licensee stated "she opened right up to me". He stated she cried a few times.

38. Licensee asked patient 12 for her phone number.

39. Licensee acknowledged he talked to patient number 12 regarding his own family issues because he had similar family issues to share.

40. Licensee engaged in self-disclosure with patient number 12 in non-limited terms and in such a manner that it impaired the nature of the nurse/patient relationship.

41. Licensee talked about patient number 12's affairs with Rapid City surgeons to those who were present at the nurses' station.

42. Licensee acknowledged he did remark to co-workers that patient number 12 had a "boob job".

43. Licensee states that nurses there were judgmental about patient number 12's boobs, saying they were fake.

44. Licensee used the confidences of patient number 12 to the patient's disadvantage when he shared information regarding her affairs with physicians to another physician and to his co-workers at the risk of compromising the patient's privacy, confidentiality, and dignity.

45. Licensee admits to holding patient number 12's hand and rubbing her back. Licensee believed that patient number 12 was using the affairs and telling her husband about them to get attention.

46. Licensee believes he tried to comfort the patient number 12 in a therapeutic manner and denies doing anything inappropriate with her.

47. Licensee admitted in e-mail to his supervisors that he was "emotionally attached" to patient number 12.

48. Licensee states that he wanted patient number 12 to know that she had a reason to live and that someone cared.

49. Licensee admits to closing the curtain on only two to three occasions, once to give patient number 12 a shot, and another to bring in a set of scrubs.

50. Licensee admitted to touching patient number 12's leg and waist.

51. The surveillance video in the ER hallway showed the frequency and time of Licensee's visits to patient number 12's room.

52. Licensee was in patient number 12's room a total of 19 times for a total of 76 minutes during the shift. (Exhibit 5)

53. Licensee's time spent with patient number 12 was excessive considering the patient was sleeping much of the time.

54. After the initial assessment and lab draw, patient number 12 would not have needed much nursing care until the return of the final lab results.

55. Licensee admits sitting next to patient number 12, having his hands under

the blanket and rubbing her back, telling her things would be okay, telling her somebody cared.

56. Licensee states that when he brought the scrubs in, patient 12 had already started to take off her clothes, so he left the scrubs.

57. Licensee states that after he left the scrubs and was turning to leave, Patient number 12 started to disrobe. Licensee states that she was putting on the scrubs quickly as she had to go to the bathroom.

58. Licensee described patient number 12 as "brazen" for starting to disrobe so quickly.

59. Licensee was present when patient number 12 changed into the scrubs.

60. Licensee failed to provide adequate privacy to patient number 12 for her to undress and change into scrubs when it was not necessary for patient's safety or for medical reasons.

61. Licensee observed patient number 12's tattoo of a butterfly on her shoulder and a lightning bolt on her lower back when he walked her to the bathroom.

62. Licensee admits that he pulled her close and may have touched her breast when walking her to the bathroom.

63. Patient number 12 was considered a vulnerable patient by virtue of her illness and attempted suicide and was therefore dependent in the nurse/patient relationship.

64. Broin did not work with patient number 12 that night, however, he did work

in the area of room number 12 that night as the room was located near the nurses' station and the blanket warmer, which were frequented by Broin.

65. Broin was aware that when a patient, like patient number 12, is on security observation that the curtain is to be open, and only closed once in a while if privacy is needed.

66. Broin observed the Licensee going in and out of patient number 12's room frequently.

67. Broin observed the Licensee taking a set of green scrubs in to patient number 12 to have her change her clothes. When Licensee took in the scrubs, he closed the curtain and was in with patient number 12 for a couple of minutes.

68. Broin observed the Licensee enter patient number 12's room toward the end of her stay in the ER to supposedly remove an IV and again, Licensee shut the curtain.

69. Broin and other staff expressed concern about the amount of time Licensee was spending in patient number 12's room that night.

70. Broin observed the Licensee sitting on a doctor's stool next to patient number 12's bed. Licensee's hands were on the edge of the cart and half of his hands were covered by a blanket. Patient was turned away from the Licensee, laying in a fetal position.

71. Broin, who observed Licensee's hands under the blankets, went to get security officer Kiewel, to get confirmation of Licensee's hand placement and whether that was unusual. By the time Kiewel could observe, Licensee had removed his hands.

72. Broin thought that the Licensee's activities that he observed were inappropriate.

73. The observations by Broin were of such a nature that he reported it to the security officer Kiewel and asked a female nurse if he should report what he saw.

74. The concerns expressed by Broin included Licensee being present when the patient was changing her clothes and when the Licensee was sitting at the bedside with his hand under the blankets.

75. The Board of Nursing finds the testimony of Joe Broin credible.

76. Kiewel was employed as a hospital security officer and was working in the emergency room on Friday night, January 22, 2010. Kiewel was called to the ER and assigned suicide watch beginning at 7:55 p.m. on patient number 12 pursuant to protocol for this type of patient.

77. Kiewel observed patient number 12 asleep in the room upon his arrival. The curtains were open and she would wake up periodically.

78. Kiewel sits outside the room of a patient who is to be watched to assure that patient does not harm him/herself.

79. For patients on suicide watch, such as patient number 12, protocol requires that curtains need to be opened so that security can watch the patient.

80. Kiewel stood or positioned himself at the nurses' station so that he could see patient number 12 in her room. His goal is to make sure that she did not hurt herself or staff.

81. Licensee shared with Kiewel that patient number 12 had asked why Kiewel was outside her room watching her.

82. Licensee advised Kiewel that he [Licensee] had explained to patient number 12 the mental health protocol.

83. Licensee said to Kiewel "she's not bad looking, she's got a nice rack, but they're fake". He then stated to Kiewel that he had "dated a couple of strippers who had fakes".

84. The comments regarding patient number 12's breasts took Kiewel by surprise as it was not usual to hear these types of comments from a professional about a patient.

85. Kiewel observed Licensee going into patient number 12's room more frequently than usual.

86. Licensee shared with Kiewel the reasons that patient number 12 was in the ER. Kiewel thought it odd that he shared why she was in the ER and shared that she was involved with a physician who was not her husband.

87. Kiewel observed Licensee usually closing the door and curtain when he would go in to patient number 12's room. When he took in the scrubs he closed the curtain, not the door.

88. Broin came to Kiewel asking him to come and observe the placement of Licensee's hands under a blanket. Kiewel did not see the activity, but Kiewel felt Broin had legitimate concerns.

89. When Licensee took in the scrubs to patient number 12, Kiewel heard Licensee tell the patient that when she was done changing to turn on the call light and he would come back in. Kiewel observed Licensee coming out of patient number 12's room two and a half minutes later and the call light immediately came on.

90. Due to Licensee's lengthy stays in the room, security was asked to review the video by administration the following week.

91. Kiewel observed Licensee escorting patient number 12 to the bathroom by taking her left arm and putting his other arm around her waist, walking her to the bathroom. Kiewel observed the patient walking independently back from the bathroom.

92. Kiewel logged the scrubs incident and the restroom incident in his security log book.

93. The Board of Nursing finds the testimony of Mike Kiewel credible.

94. On January 23, 2010, the night following the patient 12 incident, Broin reported his observations regarding Licensee and patient number 12 to Tim Ripley, who in turn reported the behavior of Licensee to Feterl in the early morning hours of January 24, 2010. Feterl immediately placed Licensee on administrative leave.

95. After being advised of Licensee's inappropriate behaviors, Feterl began her investigation of the allegations on Sunday morning, January 24, 2010. On January 25, 2010, she reported the concerns to Dale Gisi ("Gisi"), Director of Human Resources. An interview of Ripley was scheduled with Feterl and Gisi for January 26, 2010.

96. On January 26, 2010, Feterl, Galbraith, and Gisi interviewed Ripley regarding the incidents of January 22 and 23, 2010.

97. On January 26, 2010, at the same time that Ripley was being interviewed, Patient number 12 and her husband came into the Customer Service Department of the hospital and made a complaint alleging a sexual behavior violation against her caregiver in the ER on Friday, January 22, 2010. This complaint was made to Eric Hupp ("Hupp"), a Patient Advocate of Rapid City Regional Hospital. Hupp immediately reported the complaint to Galbraith.

98. Patient number 12 described the nurse who had cared for her and alleged he kissed and touched her breasts, kissed her stomach, commented on her tattoos, described her as his "hot little patient", and discussed with her the problems she was having with her husband.

99. Galbraith first became aware of issues with the Licensee over the weekend and again on Tuesday morning, January 26, 2010, when Hupp, a Patient Advocate at the Rapid City Regional Hospital, reported to her that patient number 12 and her husband had come in to report alleged inappropriate sexual behavior by a male nurse in the ER.

100. After receiving the report from Hupp, Galbraith then talked with Gisi and Feterl about what actions to take.

101. Galbraith was concerned about the need to report patient number 12's complaint to the Department of Health.

102. Galbraith called patient number 12 and set a time for herself and Feterl to interview her alone. Galbraith took notes during the interview which occurred in the evening on Wednesday, January 27, 2010. Galbraith's notes document the patient alleging that Licensee touched and kissed her breasts, kissed her mouth, looked at her tattoos on her stomach, kissed her stomach, touched her underneath the blanket on her hip and thigh, and called her his "hot patient". (Exhibit 2)

103. During the January 27, 2010 interview of patient number 12, Feterl and Galbraith found patient number 12 to be fragile, afraid, emotional, and distraught.

104. Patient number 12 was vulnerable and afraid no one would believe her. Galbraith found her credible.

105. On January 29, 2010, Licensee was interviewed by Feterl, Galbraith, and Gisi regarding the incidents that had occurred on Friday, January 22, 2010 and January 23, 2010. Licensee mentioned patient number 12. Galbraith's notes documented Licensee's interactions, comments, and admissions regarding patient number 12. (Exhibit 3)

106. Licensee did not have any idea why he was being placed on administrative leave. When asked whether there was any unusual patient in the ER on Friday night, the Licensee did reference the suicidal patient number 12 and admitted to spending a lot of time with her.

107. The Board of Nursing finds the testimony of Feterl credible.

108. The Board of Nursing finds the testimony of Galbraith credible.

109. An e-mail that Rapid City Regional Hospital received from the Licensee dated February 1, 2010 contained different factual statements than what he conveyed to Galbraith during the interview she conducted with Licensee. (Exhibit 4)

110. Licensee believes that patient number 12 said untrue things about him in her interview. Licensee believes that she came to the hospital to complain because she gets a rise out of her husband this way and gets a response from her husband by saying she is with other guys and she seems to especially have a thing for people in power.

111. Licensee showed no remorse or concerns for the patient when confronted with allegations by the administration of Rapid City Regional Hospital.

112. Licensee repeatedly states that he did nothing that was "sexual".

113. Licensee failed to maintain professional boundaries with patient number 12 and made a conscious decision to deviate from appropriate boundaries.

114. Licensee made statements to others regarding patient number 12's breasts, body, tattoos, sexual history, and other private information that did not have a legitimate health care purpose.

115. Licensee violated the nurse/patient relationship when he suggested or discussed calling patient number 12 after the professional relationship ended.

116. Licensee touched and rubbed the patient's back with hands under a blanket while sitting behind the patient in an inappropriate manner.

117. Licensee exploited the professional relationship with patient number 12 for the nurse's own emotional and/or sexual advantage.

PATIENT NUMBER 19

118. That on January 23, 2010, Licensee established a nurse/patient relationship with patient number 19, who was brought into the Rapid City Regional Hospital Emergency Room.

119. On January 23, 2010, Ripley, in trying to locate Licensee for a phone call, entered patient number 19's room and found Licensee trying to find fetal heart tones on the female patient who was early in a pregnancy.

120. Ripley observed that patient number 19's abdomen was exposed and Licensee had placed a fetal heart tone monitor too low on her pelvis.

121. Licensee did not have a female present while he was checking fetal heart tones of patient number 19.

122. Female nurses and techs were on duty the night patient 19 was admitted.

123. Licensee denies that he placed the fetal heart tone monitor too low on patient number 19.

124. Licensee admits to performing the fetal heart tones on patient number 19, which he admits were difficult for him to obtain. (Exhibit 4)

125. Licensee believes patient number 19 was comfortable with him doing the fetal heart tones in her early stage of pregnancy.

126. Approximately two months prior to patient number 19's admission, an e-mail, dated November 11, 2009, had been sent by Feterl to her entire staff stating that female patients who come in with abdominal issues should be cared for by female nurses.

127. It was discussed in orientation and with all male nurses that only female nurses were to perform early term fetal heart tones on OB patients, such as patient 19.

128. Male nurses do perform fetal heart tones in the ER on later term OB patients as the fetal heart tones are easier to assess than on early OB patients.

129. According to protocol, male nurses should not perform fetal heart tones on OB patients, especially unescorted.

130. Ripley had talked to all male care givers about the e-mail policy directive in regards to the attendance of male nurses caring for particular female patients.

131. Licensee denied that there is any protocol prohibiting male nurses from doing fetal heart tones on OB patients such as patient number 19, but admits it is routine to ask for a female to be present.

132. Licensee admits to receiving the policy e-mail regarding male care givers performing these procedures, but concluded patient number 19 was different as she was not an abdominal pain patient. His understanding was that females would be taking abdominal pain patients because of the possibility of pelvic exams but that the e-mail did not apply to males performing fetal heart tones on other patients. (Exhibit B)

133. Licensee admits to performing fetal heart tones on a ten week gestation

patient before.

134. At approximately 12:30 a.m. on January 24, 2010, Ripley reported the fetal heart tone incident, which had occurred earlier during the night shift, to the house supervisor. Ripley then called Feterl at home. He felt it was unsafe for Licensee to care for female patients.

135. In the conversation, Ripley told Feterl of the incident occurring with patient number 12 on Friday, January 22, 2010 and with patient number 19 on January 23, 2010. Feterl advised that Ripley should place the Licensee on administrative leave immediately. Licensee was sent home immediately.

136. The Board of Nursing finds the testimony of Tim Ripley credible.

137. Licensee failed to maintain professional boundaries with patient number 19 and made a conscious decision to deviate from appropriate boundaries as well as ER protocol.

138. On Sunday morning, January 24, 2010, Feterl came into the ER to begin her investigation.

139. On January 25, 2010, Feterl, Galbraith, and Gisi continued their investigation of the incidents involving the Licensee which had occurred with patient number 12 and patient number 19.

THREAT AGAINST RIPLEY

140. Two weeks after Licensee was terminated from Rapid City Regional

Hospital, he posted a Facebook message stating that "If [he] ran into Tim R in a dark alley, [he] wouldn't care if there were witnesses". (Exhibit 7)

141. The Facebook posting caused Ripley to fear bodily harm upon himself by the Licensee and he did obtain Temporary Protection Order against the Licensee. The said Protection Order was not extended beyond the temporary period. (Exhibit C)

142. Licensee states the Facebook posting regarding Ripley was not meant to be threatening, but that Licensee was just frustrated after being terminated from his employment on February 2, 2010.

WOMEN FROM SHELTER

143. Feterl investigated a complaint against Licensee in July of 2009 after a counselor at a local abuse shelter came forward on behalf of two female clients who, in group therapy, had described a nurse in the ER who had cared for them and had made inappropriate comments to them.

144. The two women from the abuse shelter were identified, their charts pulled, and it was determined that it was the Licensee who had cared for them.

145. One of the clients, "SM", came forward and was interviewed by Feterl and Galbraith on July 23, 2009. SM indicated that the Licensee stared at her, commented on her eyes and rubbed her back, making her uncomfortable.

146. Patient SM was a vulnerable patient. She was afraid she would not be believed.

147. Galbraith documented the meeting with SM who had complained about inappropriate behavior from a male nurse in the ER. (Exhibit 1)

148. Licensee met with Feterl after July 23, 2009 to discuss professional boundaries as it related to patient SM.

149. Licensee's admitted to touching SM's back and shoulders to provide reassurance as he does with many patients.

150. Licensee's wife calls him a "flirt".

151. The Licensee states that he wants to be memorable to his patients, to make people feel good about their visits.

152. Licensee admits that in July, 2009 he was told by Feterl to watch out with his compliments to be sure that his comments were not taken the wrong way.

153. No corrective action was taken against Licensee in July, 2009.

OTHER

154. Licensee was terminated from his job at Rapid City Regional Hospital on February 2, 2010.

155. Licensee does not see any boundary issues, and if he had to do things over again, he would do the same thing.

156. The Board of Nursing does not find the testimony of Licensee credible.

From the foregoing Findings of Fact, the Board draws the following:

CONCLUSIONS OF LAW

1. That the Board has jurisdiction and authority over this matter pursuant to SDCL §§ 36-9-1.1 and 36-9-49.

2. The Board had the opportunity to view all testimony in this hearing, to witness the demeanor of witnesses, and to review all evidence in this matter.

3. That the Licensee's conduct as identified in the Findings of Fact is by clear and convincing evidence in violation of SDCL § 36-9-49(5) in that he negligently, willfully, or intentionally acted in a manner inconsistent with the health and safety of persons entrusted to his care.

4. That the Licensee's conduct as identified in the Findings of Fact is by clear and convincing evidence in violation of SDCL § 36-9-49(10), in that he is guilty of incompetent, unprofessional, and dishonorable conduct.

5. That the Licensee's conduct as identified in the Findings of Fact is by clear and convincing evidence in violation of SDCL § 36-9-49(12) in that he engaged in sexual contact with a patient.

6. That the Licensee's conduct as identified in the Findings of Fact is by clear and convincing evidence in violation of the code of ethics of nursing as set forth in ARSD 20:48:04:01(1)(d), which provides that the Board "recognizes the Scope and Standards of Practice 2004 and the Code of Ethics for Nurses with Interpretive Statements 2001" as published by the American Nurse Association as a criteria for assuring safe and effective practice following licensure. The code of ethics requires an RN to function within an

established guideline and uphold the basic standards of practice.

7. That the evidence of violation by the Licensee of the Nurse Practice Act and the Nursing Code of Ethics is clear and convincing and the Board of Nursing has met its burden of proof.

THEREFORE, let an order be entered accordingly:

ORDER

Based on the Findings of Fact and Conclusions of Law, the South Dakota Board of Nursing hereby orders:

1. That the Licensee's license to practice as a registered nurse in the State of South Dakota is hereby revoked.

2. That the Licensee may petition according to SDCL § 36-9-57 for reinstatement of his license at any time for "good cause" as the Board in its discretion may determine.

3. That the Licensee shall turn in his license to the Board of Nursing within ten (10) days of the date of this Order.

4. That the Licensee is hereby notified that any practice as, or holding himself out as, a registered nurse during the terms of this revocation is in violation of SDCL § 36-9-68.

Dated this 20th day of October, 2010.

SOUTH DAKOTA BOARD OF NURSING

Deb Soholt

Deb Soholt, Chair

IT IS NOW HEREBY ORDERED:

That the above Finding of Fact, Conclusions of Law and Order of Revocation were adopted by the South Dakota Board of Nursing on the 20th day of October, 2010.

Dated this 20th day of October, 2010.

SOUTH DAKOTA BOARD OF NURSING

Gloria Damgaard

Gloria Damgaard, Executive Director